STANDARD RELEASE for Sibshops Participants

I, ____, give my consent to the
Parent/ Caregiver's Name

Sibshop Interagency Team to:

_____ Use my likeness or my child's likeness in ***print materials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs
(ie- photos in Newsletters, for Sibshops presentations, etc).

_____ Use my likeness r my child's likeness in ***television news stories or television commercials*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***artwork*** in print materials for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Use my child's ***likeness and/or artwork on the World Wide Web*** for the purpose of dispelling the myth and misunderstanding surrounding being a sibling of a child with special needs.

_____ Provide my ***child's email and/or home address and phone number*** to all Sibshops participants

____
Child's Name

____
Date

____
Parent/Caregiver's Signature

____
Witness

Sibshop Interagency Team:

Mt. Washington Pediatric Hospital | The Arc Montgomery County

Revised February 2011

SIBSHOPS
Parental Release for:

EMERGENCY MEDICAL TREATMENT

I, ____, parent or guardian or
Parent's Name

____________________________________ , give permission to the Sibshops staff to
Child's Name
Staff to secure, if necessary, emergency medical treatment for my child. I realize the

Sibshops staff will make every effort to contact me, or any additional local emergency

contacts that are named here, after securing emergency medical care, including calling

911 if necessary. This permission is granted for the Sibshops offered from:

___March 1 2016_____________ to ___March 1 2017_____________.
Date Date

Sibshops of Maryland is an interagency consortium involving:
Mt. Washington Pediatric Hospital and The Arc Montgomery County, and their staff, volunteers and sponsors.

Parent/Guardian ____
Name

Signature ____

Date ____

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SIBSHOPS

Participant EMERGENCY MEDICAL TREATMENT Information

Child's Name ________________________________ **Date of Birth** __________________

Address ____

City _______________________ **Zip Code** _____________________

Allergies (Include Food & Medications) ____

____

Medications taken ____

Primary Doctor *Name* ____

Phone ____

Emergency Phone ____

Health Insurance *Name* ____

Phone ____

Policy # ____

Mother's Name ____

Contact # ____

Father's Name ____

Contact # ____

Additional Emergency Contacts:

Name: ______________________________________ ***Phone #*** _______________________

Name: ______________________________________ ***Phone #*** _______________________

Revised February 2011